NC DMA Pharmacy Request for Prior Approval - Botox/Dysport/Myobloc/Xeomin

Recipient Information **DMA-0014**

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information
Name:_____ Phone #:_____ Ext:_____

Drug Information

9. Drug Name: ☐ Botox ☐ Dysport ☐ Myobloc ☐ Xeomin 10. Strength: _____ 11. Quantity Requested: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other:_____

Clinical Information

1. What is the diagnosis or indication for the medication?

Botox, Dysport, Xeomin

a. ☐ Blepharospam
b. ☐ Disorders of eye movement (strabismus)
e. ☐ Upper limb spasticity in adults
f. ☐ Severe axillary hyperhidrosis (ANSWER QUESTIONS 2 AND 3 BELOW)
g. ☐ Chronic anal fissure refractory to conservative treatment
h. ☐ Esophageal achalasia recipients in whom surgical treatment is not indicated
i. ☐ Spasticity (e.g., from multiple sclerosis, neuromyelitis optica, other demyelinating diseases of the central nervous system, spastic hemiplegia, quadriplegia , hereditary spastic paraplegia, spinal cord injury, traumatic brain injury, and stroke)
j. ☐ Schilder's disease
m. ☐ Infantile cerebral palsy, specified or unspecified
p. ☐ Secondary focal hyperhydrosis (Frey's syndrome)
r. ☐ Laryngeal dystonia and adductor spasmodic dysphonia

Botox, Dysport, Myobloc, Xeomin

c. ☐ Sialorrhea
d. ☐ Spamodic torticollis, secondary to cervical dystonia
k. ☐ Congenital diplegia – infantile hemiplegia
n. ☐ Hemifacial spasms
q. ☐ Idiopathic (primary or genetic) torsion dystonia
l. ☐ Achalasia and Cardiospasm
o. ☐ Symptomatic (acquired) torsion dystonia

2. Does the patient have documented medical complications due to hyperhidrosis? ☐ Yes ☐ No List: _____
3. Has the patient failed a 6-month trial of conservative management including the use of topical aluminum chloride or extra strength antiperspirant? ☐ Yes ☐ No
List product (s) tried: _____

Botox only

4a. ☐ Chronic Migraine (18 and older)

New Therapy (approval up to 6 months)

4b. Does the patient have 15 or more days each month with headache lasting 4 or more hours? ☐ Yes ☐ No
4c. Has the patient tried and failed prophylactic medications from at least 3 different drug classes (beta blockers, calcium channel Blockers, tricyclic antidepressants and anticonvulsants) each for at least 3 months of therapy? ☐ Yes ☐ No List meds tried: _____

Continuation of Therapy (approval up to 1 year)

4d. Has the patient responded favorably after the first 2 injections ? ☐ Yes ☐ No
4e. Has the average number of headache days decreased by 6 or more days from the patient's baseline headache frequency? ☐ Yes ☐ No

5a. ☐ Urinary Incontinence (Botox)
5b. Does the patient have detrusor overactivity associated with neurologic conditions? ☐ Yes ☐ No
5c. Has the patient tried and failed an anticholinergic medication? ☐ Yes ☐ No List med tried: _____
5d. Does the patient have a documented contraindication, intolerable side effects, or allergy to anticholinergic medications? ☐ Yes ☐ No

Signature of Prescriber:_____ Date:_____
*Prescriber Signature Mandatory

Fax this form to CSC at: (855) 710-1964 Pharmacy PA Call Center: (866) 246-8505

Instructions for completing this form can be found at http://www.NCTracks.com/PAformhelp

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